		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045138

Facility Name: COTILLION RIDGE NURSING CENTER

Address: 600 EAST ROBINWOOD DR. (Number) ROBINSON (City) 61938 (Zip Code)

County: Crawford

Telephone Number: (618) 544-3192 **Fax #** ( )

IDPA ID Number: 371402726

Date of Initial License for Current Owners: 11/01/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig L. Ater

(Title) Senior V. P. & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	38	Skilled (SNF)	38	13,870	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,303	10,280	2,729	25,312	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	12,303	10,280	2,729	25,312	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.00%

D. How many bed-hold days during this year were paid by Public Aid?
86 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 11/01/00

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,729

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	111,880	11,213		123,093		123,093	1,884	124,977			1
2	Food Purchase		105,020		105,020		105,020		105,020			2
3	Housekeeping	51,537	14,717		66,254		66,254		66,254			3
4	Laundry	32,821	8,730		41,551		41,551		41,551			4
5	Heat and Other Utilities			54,381	54,381		54,381	836	55,217			5
6	Maintenance	51,805	19,739	27,487	99,031		99,031	8,386	107,417			6
7	Other (specify):*											7
8	**TOTAL General Services**	248,043	159,419	81,868	489,330		489,330	11,106	500,436			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	790,656	60,905	3,475	855,036		855,036		855,036			10
10a	Therapy		164,836	280,159	444,995	(202,336)	242,659	30,483	273,142			10a
11	Activities	33,322	1,150		34,472		34,472		34,472			11
12	Social Services	28,535	821	4,851	34,207		34,207		34,207			12
13	Nurse Aide Training							1,296	1,296			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	852,513	227,712	306,485	1,386,710	(202,336)	1,184,374	31,779	1,216,153			16
	C. General Administration											
17	Administrative	69,679			69,679		69,679	51,965	121,644			17
18	Directors Fees							4,713	4,713			18
19	Professional Services			214,093	214,093		214,093	(197,755)	16,338			19
20	Dues, Fees, Subscriptions & Promotions			57,394	57,394	(39,968)	17,426	(9,044)	8,382			20
21	Clerical & General Office Expenses	91,457	8,036	8,370	107,863		107,863	147,123	254,986			21
22	Employee Benefits & Payroll Taxes			220,420	220,420		220,420	21,100	241,520			22
23	Inservice Training & Education			467	467		467	571	1,038			23
24	Travel and Seminar			8,517	8,517		8,517	(6,518)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,880	57,880		57,880	1,454	59,334			26
27	Other (specify):*			9,992	9,992		9,992	(9,992)				27
28	**TOTAL General Administration**	161,136	8,036	577,133	746,305	(39,968)	706,337	3,617	709,954			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,261,692	395,167	965,486	2,622,345	(242,304)	2,380,041	46,502	2,426,543			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER #0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			96,376	96,376		96,376	7,249	103,625			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,181	29,181		29,181	5,512	34,693			32
33	Real Estate Taxes			17,140	17,140		17,140		17,140			33
34	Rent-Facility & Grounds			274,563	274,563		274,563	4,844	279,407			34
35	Rent-Equipment & Vehicles			5,660	5,660		5,660	9,321	14,981			35
36	Other (specify):*											36
37	**TOTAL Ownership**			422,920	422,920		422,920	26,926	449,846			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					202,336	202,336		202,336			39
40	Barber and Beauty Shops			16,930	16,930		16,930		16,930			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					39,968	39,968		39,968			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			16,930	16,930	242,304	259,234		259,234			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,261,692	395,167	1,405,336	3,062,195		3,062,195	73,428	3,135,623			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	2,046	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(896)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(748)	20		17
18	Fines and Penalties				18
19	Entertainment	(10,620)	24		19
20	Contributions	4	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(160)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,996)	27		24
25	Fund Raising, Advertising and Promotional	(10,817)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,187)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	104,615		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 104,615		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 73,428		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

COTILLION RIDGE NURSING CENTER

ID# 0045138

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		2,046	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(748)	20	17
18				18
19			24	19
20		4	27	20
21				21
22		(160)	19	22
23				23
24		(9,996)	27	24
25		(10,817)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(19,671)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	1,884	0	0	0	0	0	0	0	0	1,884	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	836	0	0	0	0	0	0	0	0	836	5
6	Maintenance	0	0	8,386	0	0	0	0	0	0	0	0	8,386	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	11,106	0	0	0	0	0	0	0	0	11,106	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	30,483	0	0	0	0	0	0	0	0	0	30,483	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,296	0	0	0	0	0	0	0	0	1,296	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	30,483	1,296	0	0	0	0	0	0	0	0	31,779	16
	C. General Administration													
17	Administrative	0	0	51,965	0	0	0	0	0	0	0	0	51,965	17
18	Directors Fees	0	0	4,713	0	0	0	0	0	0	0	0	4,713	18
19	Professional Services	(160)	(205,533)	7,938	0	0	0	0	0	0	0	0	(197,755)	19
20	Fees, Subscriptions & Promotions	(11,565)	0	2,521	0	0	0	0	0	0	0	0	(9,044)	20
21	Clerical & General Office Expenses	0	0	147,123	0	0	0	0	0	0	0	0	147,123	21
22	Employee Benefits & Payroll Taxes	0	0	21,100	0	0	0	0	0	0	0	0	21,100	22
23	Inservice Training & Education	0	0	571	0	0	0	0	0	0	0	0	571	23
24	Travel and Seminar	(10,620)	0	4,102	0	0	0	0	0	0	0	0	(6,518)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,454	0	0	0	0	0	0	0	0	1,454	26
27	Other (specify):*	(9,992)	0	0	0	0	0	0	0	0	0	0	(9,992)	27
28	**TOTAL General Administration**	(32,337)	(205,533)	241,487	0	0	0	0	0	0	0	0	3,617	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,337)	(175,050)	253,889	0	0	0	0	0	0	0	0	46,502	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	7,249	0	0	0	0	0	0	0	7,249	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(896)	0	0	6,408	0	0	0	0	0	0	0	5,512	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	4,844	0	0	0	0	0	0	0	4,844	34
35	Rent-Equipment & Vehicles	2,046	0	0	7,275	0	0	0	0	0	0	0	9,321	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,150	0	0	25,776	0	0	0	0	0	0	0	26,926	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(31,187)	(175,050)	253,889	25,776	0	0	0	0	0	0	0	73,428	45

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Therapy	100.00%			2
3	V								3
4	V	19	Adjustment for Related Organization	205,533	Heritage Enterprises, Inc.	100.00%		(205,533)	4
5	V								5
6	V	10a	Adjustment for Related Organization	154,215	GreenTree Pharmacy	100.00%	184,698	30,483	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 359,748			$ 184,698	$ * (175,050)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 1,884	$ 1,884	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				0		17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				836	836	19
20	V	6	Maintenance				8,386	8,386	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,296	1,296	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				51,965	51,965	29
30	V	18	Directors Fees				4,713	4,713	30
31	V	19	Professional Services				7,938	7,938	31
32	V	20	Fees, Subscription, Promotions				2,521	2,521	32
33	V	21	Clerical & General Office Expenses				147,123	147,123	33
34	V	22	Employee Benefits & Payroll Taxes				21,100	21,100	34
35	V	23	Inservice Training & Education				571	571	35
36	V	24	Travel and Seminar				4,102	4,102	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,454	1,454	38
39	Total			$		$ 253,889	$ * 253,889		39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15
16	V	30	Depreciation				7,249	7,249	16
17	V	31	Amortization of Pre-Op & Org				0		17
18	V	32	Interest				6,408	6,408	18
19	V	33	Real Estate Taxes				0		19
20	V	34	Rent-Facility & Grounds				4,844	4,844	20
21	V	35	Rent-Equipment & Vehicles				7,275	7,275	21
22	V	36	Other				0		22
23	V	38	Medically Nec Transportation				0		23
24	V	39	Ancillary Service Centers				0		24
25	V	40	Barber and Beauty Shops				0		25
26	V	41	Coffee and Gift Shops				0		26
27	V	42	Other				0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 25,776	$ * 25,776	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Heritge Enterprises -Allocation for Related Party Entity								$ 51,965	line 17/18, col	1
2	Heritge Enterprises -Allocation								4,713	line 17/18, col	2
3											3
4	Cheryl Lowney	Executive Vice Presi	Management	20.00							4
5	Steve Wannemacher	President	Management	20.00							5
6	Connie Hoselton	Sr Vice President	Management	20.00							6
7	Craig Ater	Sr Vice President	Management	20.00							7
8	Estate of Joe Warner			20.00							8
9											9
10											10
11											11
12											12
13								TOTAL	$ 56,678		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,403	24	$ 62,023	$ 62,023	73	$ 1,884	1
2	2	Food Purchase	Beds	2,403	24	0	0	73	0	2
3	3	Housekeeping	Beds	2,403	24	0	0	73	0	3
4	4	Laundry	Beds	2,403	24	0	0	73	0	4
5	5	Heat & Other Utilities	Beds	2,403	24	27,509	0	73	836	5
6	6	Maintenance	Beds	2,403	24	276,052	67,064	73	8,386	6
7	7	Other	Beds	2,403	24	0	0	73	0	7
8	9	Medical Director	Beds	2,403	24	0	0	73	0	8
9	10	Nursing & Medical Records	Beds	2,403	24	0	0	73	0	9
10	11	Activities	Beds	2,403	24	0	0	73	0	10
11	12	Social Service	Beds	2,403	24	0	0	73	0	11
12	13	Nurse Aide Training	Beds	2,403	24	42,658	42,572	73	1,296	12
13	14	Program Transportation	Beds	2,403	24	0	0	73	0	13
14	15	Other	Beds	2,403	24	0	0	73	0	14
15	17	Administrative	Beds	2,403	24	1,710,580	0	73	51,965	15
16	18	Directors Fees	Beds	2,403	24	155,144	0	73	4,713	16
17	19	Professional Services	Beds	2,403	24	261,316	0	73	7,938	17
18	20	Fees, Subscription, Promotions	Beds	2,403	24	82,980	0	73	2,521	18
19	21	Clerical & General Office Expens	Beds	2,403	24	4,842,980	4,501,882	73	147,123	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,403	24	694,554	0	73	21,100	20
21	23	Inservice Training & Education	Beds	2,403	24	18,789	0	73	571	21
22	24	Travel and Seminar	Beds	2,403	24	135,033	0	73	4,102	22
23	25	Other Admin. Staff Transportatio	Beds	2,403	24	0	0	73	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	0	73	1,454	24
25	TOTALS					$ 8,357,495	$ 4,673,541		$ 253,889	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,403	24	$	$	73	$	1
2	30	Depreciation	Beds	2,403	24	238,628		73	7,249	2
3	31	Amortization of Pre-Op & Org	Beds	2,403	24			73		3
4	32	Interest	Beds	2,403	24	210,931		73	6,408	4
5	33	Real Estate Taxes	Beds	2,403	24			73		5
6	34	Rent-Facility & Grounds	Beds	2,403	24	159,466		73	4,844	6
7	35	Rent-Equipment & Vehicles	Beds	2,403	24	239,478		73	7,275	7
8	36	Other	Beds	2,403	24			73		8
9	38	Medically Nec Transportation	Beds	2,403	24			73		9
10	39	Ancillary Service Centers	Beds	2,403	24			73		10
11	40	Barber and Beauty Shops	Beds	2,403	24			73		11
12	41	Coffee and Gift Shops	Beds	2,403	24			73		12
13	42	Other	Beds	2,403	24			73		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 848,503	$		$ 25,776	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Alpha Community Bank		xx	Purchase Operations & Equipm	$12,808.00	11/1/00	$ 1,055,000	$ 669,411	11/1/2005	variable	$ 28,290	1
2	Loan Fee Amort										891	2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital								6
7	Central Office Allocation		xx	Working Capital							6,408	7
8												8
9	TOTAL Facility Related				$12,808.00		$ 1,055,000	$ 669,411			$ 35,589	9
	B. Non-Facility Related*											
10	Interest Income										(896)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (896)	14
15	TOTALS (line 9+line14)						$ 1,055,000	$ 669,411			$ 34,693	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	17,009	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	16,658	2
3. Under or (over) accrual (line 2 minus line 1).	$	(351)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	17,491	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	17,140	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COTILLION RIDGE NURSING CENTER COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0045138

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05427033041000	COTILLION RIDGE NURSING CEN	$ 215.00	$ 215.00
2.	05427033042000		$ 16,443.00	$ 16,443.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 16,658.00	$ 16,658.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	73				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Acquisition of Building Improvements from prior Operator			2001	154,177						9
10											10
11	Dinning Room/Day Room Addition---Outside Contractor			2001	164,291						11
12	Dinning Room/Day Room Addition---Design			2001	50,288						12
13	Dinning Room/Day Room Addition---Wallcoverings			2001	9,670						13
14											14
15	Dinning Room/Day Room Addition---Outside Contractor			2002	66,633						15
16	Dinning Room/Day Room Addition---Design			2002	4,665						16
17	Heating Duct Replacement			2002	12,146						17
18											18
19	Dinning Room/Day Room Addition---Paid by ProCare			2002	200,750						19
20	directly to General Contractor										20
21											21
22	Heat Pump			2003	12,720						22
23	Compressor			2003	1,333						23
24	A/C Unit			2003	2,569						24
25	Water Heater			2003	7,262						25
26	Sprinkler Head Replacements			2003	3,993						26
27	Asphalt Sealing			2003	1,260						27
28	idph			2003	8,618						28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							7,249	7,249		34
35	Book Depreciation					31,798		31,798		67,745	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 700,375	$ 31,798		$ 39,047	$ 7,249	$ 67,745	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 700,375	$ 31,798		$ 39,047	$ 7,249	$ 67,745	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 700,375	$ 31,798		$ 39,047	$ 7,249	$ 67,745	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 496,213	$ 64,578	$ 64,578	$		$ 195,766	71
72	Current Year Purchases	4,481						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 500,694	$ 64,578	$ 64,578	$		$ 195,766	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,201,069	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 96,376	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 103,625	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,249	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 263,511	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ProCare, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		73	11/1/00	$ 274,563	10	10	3
4	Additions							4
5								5
6								6
7	TOTAL		73		$ 274,563 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning 11/1/00
Ending 11/1/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ 274,563
13.	/2005	$ 274,563
14.	/2006	$ 274,563

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,981 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 95,337	$		$ 95,337	1
2	Licensed Speech and Language Development Therapist		hrs			45,579			45,579	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			131,287	939		132,226	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				194,380		194,380	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					7,956			7,956	13
14	TOTAL			$		$ 280,159	$ 195,319		$ 475,478	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER **#** 0045138 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 321,231	$	1
2	Cash-Patient Deposits	1,034		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	297,276		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,598		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 633,139	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	499,644		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	451,444		16
17	Accumulated Depreciation (book methods)	(263,511)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	149,866		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 837,443	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,470,582	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 127,086	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,034		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	3,000		31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,491		32
33	Accrued Interest Payable	2,132		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Escrow	(3,362)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 147,381	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	669,411		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 669,411	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 816,792	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 653,790	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,470,582	$	48

***(See instructions.)**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 484,046	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 484,046	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	344,744	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(175,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 169,744	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 653,790	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,255,314	1
2	Discounts and Allowances for all Levels	(842,008)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,413,306	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	693,033	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 693,033	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,519	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	281,648	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	537	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 299,704	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	896	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 896	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,406,939	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	489,330	31
32	Health Care	1,386,710	32
33	General Administration	746,305	33
	B. Capital Expense		
34	Ownership	422,920	34
	C. Ancillary Expense		
35	Special Cost Centers	16,930	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,062,195	40
41	**Income before Income Taxes (line 30 minus line 40)****	344,744	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 344,744	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,744	2,080	$ 46,621	$ 22.41	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	11,173	11,857	196,051	16.53	3
4	Licensed Practical Nurses	6,530	7,184	79,946	11.13	4
5	Nurse Aides & Orderlies	43,641	46,536	391,796	8.42	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,320	7,047	76,242	10.82	8
9	Activity Director					9
10	Activity Assistants	3,684	4,011	33,322	8.31	10
11	Social Service Workers	1,896	2,080	28,535	13.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,760	14,821	111,880	7.55	15
16	Dishwashers					16
17	Maintenance Workers	4,234	4,482	51,805	11.56	17
18	Housekeepers	7,528	8,087	51,537	6.37	18
19	Laundry	3,979	4,442	32,821	7.39	19
20	Administrator	2,080	2,080	69,679	33.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,596	6,258	91,457	14.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,165	120,965	$ 1,261,692 *	$ 10.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		18,000		36
37	Medical Records Consultant		925		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,553		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,851		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,329		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Brush	Admin	0	$ 69,679
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,679

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 213,933
		0
		0
		0
Legal Fees (Adjusted to zero)		160
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 214,033

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,971
Unemployment Compensation Insurance	10,441
FICA Taxes	96,519
Employee Health Insurance	79,200
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	38
Employee Benefits -	12,251
Employee Benefits - central office	21,100
TOTAL (agree to Schedule V, line 22, col.8)	$ 241,520

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	153
Health Care Worker Background Check	
(Indicate # of checks performed)	329
Central Office Allocation	2,521
Promotional Advertising	6,933
Public Relations	3,884
Dues and Subscriptions	5,378
License and Fees	749
Less: Public Relations Expense	(3,884)
Non-allowable advertising	(748)
Yellow page advertising	(6,933)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,382

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,725
	113
Seminar Expense	4,679
Non Allowable	(10,620)
Central Office Allocation	4,102
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **39,968**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **215**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Pellman & Dold** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **Not Complete as of this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount	
1009			PETTY CASH	321,231						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	297,276						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1135			ACCOUNTS RECEIVABLE-IC							
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	13,598						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY							
1310			SUPPLIES INVENTORY							
1409			LAND	0						
1450			FURNITURE & EQUIPMENT	451,444						
1460			ACCUM DEPR-FURN & EQUIP	-195,766						
1475			BUILDING & IMPROVEMENTS	499,644						
1490			ACCUM DEPR-BUILDING	-67,745						
1530			RESIDENT FUNDS	1,034						
1550			LOAN FEES	149,866						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	0						
2010			ACCOUNTS PAYABLE	-127,086						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	0						
2110			ACCRUED VACATION PAY	0						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-3,000	-3,000					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLE	-2,132						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	3,362						
2350			REAL ESTATE TAX PAYABLE	-17,491						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS							
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-1,034						
2600			MORTGAGE PAYABLE	-669,411						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-309,046						
2970			PROFIT/LOSS FOR PERIOD	-344,744						
3007.1			PATIENT DAYS-PRIVATE	10,426						
3007.2			PATIENT DAYS-IPA	12,389						
3007.3			PATIENT DAYS-MEDICARE	2,729						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-1,081,680		0	0	0	0	
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1	BASIC CHARGE-IPA	-1,187,770		0	0	0	0	
3030		1	BASIC CHARGE-MEDICARE	-841,238		0	0	0	0	
3035		4	DAY CARE/HOME CARE			0	0	0	0	
3040		1	LIGHT NURSING CARE	0		0	0	0	0	
3050		1	MEDIUM NURSING CARE			0	0	0	0	
3060		1	HEAVY NURSING CARE			0	0	0	0	
3061		1	SKILLED NURSING CARE							
3080		1	NURSING SUPPLIES-PRIVATE	-144,352		0	0	0	0	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1	NURSING SUPPLIES MED PT B							
3100		17	DRUGS	-281,648		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-693,033		0	0	0	0	
3111		6	PT-IPA			0	0	0	0	
3112		6	PT-MEDICARE PART A			0	0	0	0	
3113		6	PT-MEDICARE PART B			0	0	0	0	
3130		1	PUBLIC AID ASSESSMENT INC							
3140		19	LABORATORY INCOME			0	0	0	0	
3150		6	SPEECH/OT-PRIVATE			0	0	0	0	
3151		6	SPEECH/OT-IPA			0	0	0	0	
3152		6	SPEECH/OT-MED PART A			0	0	0	0	
3153		6	SPEECH/OT MED PART B							
3410		2	IPA DISCOUNTS	842,008		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	-17,519		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	-274		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	-537		0	0	0	0	
3600		21	MISC INCOME	0		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	84,710	91,457	21	1	17	0	
4111			ADMINISTRATOR WAGES	69,679	69,679	17	1	0	0	
4115			VACATION & SICK - G&A	6,747		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	12,251	220,420	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	38		22	3	0	0	
4130			EMPLOYEE SCHOLORSHIP WA(	0		21	1	0	0	
4135			EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0	
4220			DIRECTORS FEES			18	3	0	0	
4250	4255		OFFICE SUPPLIES	8,036	8,036	21	2	0	0	
4260			TELEPHONE	8,370	8,370	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	467	467	23	3	16	0	
4280			GENERAL TRAVEL	3,725	8,517	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	113		24	3	19	0	
4285			EDUCATION & SEMINAR	4,679		24	3	19	-10,620	***
4290			HELP WANTED ADVERTISING	153	57,394	20	3	0	0	-39,968
4291			PROMOTIONAL ADVERTISING	6,933		20	3	25	-6,933	
4292			PUBLIC RELATIONS	3,884		20	3	25	-3,884	
4300			LICENSES & FEES	40,717		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	5,378		20	3	17	-748	
4320			CONTRIBUTIONS	-4		27	3	20	4	
4350			PROFESSIONAL FEES	8,560	214,093	19	3	22	-160	
4355			MEDICAL DIRECTOR	18,000	18,000	9	3	0	0	
4360			UTILIZATION REVIEW			10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	925		10	3	0	0	
4363			PHARMACIST FEES	1,553		10	3	0	0	
4364			SOC SERV/ACT CONSULT	4,851	4,851	12	3	0	0	
4370			TV RENTAL	-3,589		35	3	5	2,046	
4380			INCOME TAXES		9,992	27	3	26	0	
4383			BACKGROUND CHECKS	329		20	3	26	0	
4400			PAYROLL TAXES	101,983		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	4,977		22	3	0	0	
4410			GROUP INSURANCE	79,200		22	3	0	0	
4420			LIABILITY INSURANCE	57,880	57,880	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANCI	21,971		22	3	0	0	
4450			CENTRAL OFFICE FEES	205,533		19	3	34	-205,533	
4460			BAD DEBTS	9,996		27	3	24	-9,996	
4470			LOST ITEMS-RESIDENTS	0		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	17,140	17,140	33	3	0	0	
4600			LEASED EQUIPMENT	9,249	5,660	35	3	16	0	
5110			MAINTENANCE SALARIES	49,006	51,805	6	1	0	0	
5120			MAINTENANCE SICK & VAC	2,799		6	1	0	0	
5130			ELECTRIC	38,281	54,381	5	3	0	0	
5131			NATURAL GAS	6,716		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	9,384		5	3	0	0	
5134			TRASH COLLECTION	6,040	27,487	6	3	0	0	
5140			PROPERTY PLANT REPLACEMI	2,751	19,739	6	2	0	0	
5160			GENERAL REPAIR & MAINT	16,988		6	2	0	0	
5165			MAINTENANCE CONTRACTS	21,447		6	3	0	0	
5210			DIETARY WAGES	106,086	111,880	1	1	0	0	
5220			DIETARY SICK & VAC	5,794		1	1	0	0	
5240			SALES TAX			2	3	13	0	
5248			FOOD PURCHASES	105,235	105,020	2	2	0	0	
5250			SUPPLIES-DISHWASHING	2,959	11,213	1	2	0	0	
5260			DIETARY REPLACEMENT	1,955		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	6,299		1	2	0	0	
5295			MEAL CREDIT	-215		2	2	0	0	
5310			LAUNDRY WAGES	31,213	32,821	4	1	0	0	
5340			LAUNDRY SICK & VAC	1,608		4	1	0	0	
5370			LAUNDRY REPLACEMENT	4,049	8,730	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	4,681		4	2	0	0	
5410			HOUSEKEEPING WAGES	48,086	51,537	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	3,451		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	158	14,717	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PPR	14,559		3	2	0	0	
6010			RN WAGES-MEDICARE		790,656	10	1	0	0	
6020			RN WAGES-NON MEDICARE	178,118		10	1	0	0	
6030			DON WAGES	46,621		10	1	0	0	
6035			ADON	0		10	1	0	0	
6040			RN SICK & VACATION	17,933		10	1	0	0	
6110			LPN WAGES-MEDICARE			10	1	0	0	
6120			LPN WAGES-NON MEDICARE	76,167		10	1	0	0	
6130			LPN WAGES OTHER			10	1	0	0	
6140			LPN SICK & VACATION	3,779		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	356,653		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	35,143		10	1	0	0	
6245			CONTRACT NURSES-RN	0		10	3	0	0	
6246			CONTRACT NURSES-LPN	0		10	3	0	0	
6247			CONTRACT NURSES-AIDES	0		10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270			REHAB WAGES	72,252		10	1	0	0	
6275			REHAB SICK & VAC	3,990		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	49,935	60,905	10	2	0	0	
6295			NURSING SUPPLIES	7,743		10	2	0	0	
6390			REPLACEMENT-NURSING	3,227		10	2	0	0	
6490			NURSING OTHER	997	3,475	10	3	0	0	
7280			DRUG PURCHASES	62,818	164,836	39	2	0	30,483	***
7281			DRUG PURCHASES-OTHER	101,079		39	2			
7380			LABORATORY SERVICES	7,956	280,159	39	3	0	0	
7410			HOME HEALTH SALARY			39	1	0	0	
7440			HOME HEALTH SICK & VAC			39	1	0	0	
7450			HOME HEALTH EXPENSES			39	3	0	0	
7510			ACTIVITES WAGES	31,462	33,322	11	1	0	0	
7540			ACTIVITIES SICK & VAC	1,860		11	1	0	0	
7590			ACTIVITIES SUPPLIES	1,150	1,150	11	2	0	0	
7595			ACTIVITIES FEES	0	0	11	3	0	0	
7610			PT WAGES			39	1	0	0	
7611			PT SICK & VACATION			39	1	0	0	
7620			PT FEES	131,287		39	3	0	0	***
7660			PT SUPPLIES	939		39	2	0	0	
7710			SOCIAL SERVICE WAGES	27,174	28,535	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	1,361		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	821	821	12	2	0	0	
7740			OT FEE	95,337		39	3	0	0	***
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	45,579		39	3	0	0	***
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	16,930	16,930	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910			VOLUNTEER COORDINATOR			21	1	0	0	
7940			VOL COORD SICK & VAC			21	1	0	0	
7960			VOL COORD SUPPLIES	0		21	2	0	0	
8100			RENT	274,563	274,563	34	3	0	0	
8120			INTEREST EXPENSE	28,290	29,181	32	3	14	-896	
8130			DEPRECIATION	96,376	96,376	30	3	9	0	
8150			LOAN FEE AMORTIZATION	891		32	3	0	0	60,773
9510			INTEREST INCOME	-896		32	0	10	0	
9520			MISC NON-OPERATING INCOM	0		0	0	0	0	
9700			INCOME TAXES	0		0	0	0	0	
				3,061,299	3,062,195					
					896					
GRAND TOTALS				-344,744					-206,237	
				(NET INCOME)						
				0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0
173,113

1,009	1,009 PETTY CA	321,231
1,100	1,100 ACCTS RE	297,276
1,101	1,101 ALLOW. FOR UNCOLLECTIBLES	
1,110	1,110 ACCTS RECEIV-M/C	
1,125	1,125 ACCTS RECEIV-IPA	
1,135	1,135 ACCTS RECEIV-IC	
1,140	1,140 UNAPPLIED CASH RECEIPTS	
1,145	1,145 A/R SUSPENSE-REFUNDS	
1,200	1,200 PREPAID I	13,598
1,220	1,220 OTHER PREPAID EXPENSES	
1,300	1,300 DIETARY INVENTORY	
1,310	1,310 SUPPLIES INVENTORY	
1,320	1,320 LINEN INVENTORY	
1,409	1,409 LAND	
1,450	1,450 FURNITUR	451,444
1,460		-195,766
1,475	1,475 CODE ALE	499,644
1,490	1,490 ACCUM D(	-67,745
1,530	1,530 RESIDENT	1,034
1,550	1,550 LOAN FEE	1,708
1,551	1,551 LOAN FEE	148,158
1,850	1,850 INTERCOMPANY	
2,010	2,010 ACCOUNT	-127,086
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUED PAYROLL	
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUED PTO PAY	
2,120	2,120 U.C. TAXES PAYABLE	
2,125	2,125 FICA TAXI	-3,000
2,130	2,130 FEDERAL W/H TAX PAYABLE	
2,140	2,140 STATE W/H TAX PAYABLE	
2,152	2,152 WORKERS COMP ACCRUAL	
2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2,230	2,230 PAYROLL SAVINGS	
2,235	2,240 UNITED FUND	
2,240	2,246 GROUP INSURANCE - CAFETERIA	
2,246	2,250 401K W/H	
2,250		
2,260	2,260 WAGE GARNISHMENT	
2,300	2,300 ACCRUED	-2,132
2,320	2,320 IPA PAYM	3,362
2,350	2,350 REAL EST.	-17,491
2,385		
2,400	2,400 CURRENT PORTION OF LT DEBT	
2,512	2,512 DUE TO RI	-1,034
2,600	2,600 LASALLE	-669,411
2,600		
2,625	2,625 LASALLE CONSTR. LOAN #2	
2,625		
2,695	2,695 CURRENT PORTION OF LT DEBT	
2,720	2,720 RETAINED	-309,046
	net income	-344,744
	balance	0

3,007	3,007 PATIENT I	10,426
3,007	3,007 PATIENT I	12,389
3,007	3,007 PATIENT I	2,729
3,007		
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH.	(1,081,680)
3,020	3,020 BASIC CH.	(1,187,770)
3,030	3,030 BASIC CH.	(841,238)
3,040		
3,050		
3,060		
3,061		
3,080	3,080 NURSING	(61,136)
3,081	3,081 NURSING	(52,432)
3,082	3,082 NURSING	(20,965)
3,083	3,083 NURSING	(9,819)
3,100	3,100 DRUGS-MI	(120,846)
3,101	3,101 DRUGS-OT	(160,802)
3,110	3,110 PHYSICAL	168
3,111	3,111 PHYSICAL	(1,232)
3,112	3,112 PHYSICAL	(230,420)
3,113	3,113 PHYSICAL	(99,390)
3,140	3,140 LABORAT	(8,188)
3,150		
3,151	3,151 ST/OT THI	(1,320)
3,152	3,152 ST/OT THI	(247,400)
3,153	3,153 ST/OT THI	(93,845)
3,160	3,160 X-RAY SEI	(11,406)
3,410	3,410 IPA/OTHEI	118,408
3,411	3,411 MEDICARI	64,878
3,420	3,420 MEDICARI	639,219
3,500		
3,520		
3,530	3,530 BEAUTY S	(17,519)
3,560		
3,570		
3,590	3,590 EQUIPMEI	(274)
3,595	3,595 RESIDENT	(537)
3,600		
4,110	4,110 G&A WAG	84,710
4,111	4,111 ADMINIST	69,679
4,115	4,115 G&A PTO	6,747
4,120	4,120 EMPLOYE	8,338
4,125	4,125 EMPLOYE	38
4,130		
4,135		
4,250	4,250 OFFICE SU	4,965
4,255	4,255 POSTAGE	2,035
4,260	4,260 TELEPHOI	8,370
4,275	4,275 TRAINING	467
4,276	4,276 INJURY PI	3
4,280	4,280 GENERAL	3,725
4,281	4,281 MEAL EXI	113
4,285	4,285 EDUCATI(	4,531
4,289	4,289 MEETINGS	148
4,290	4,290 HELP WAI	153
4,291	4,291 PROMOTI(	6,933
4,292	4,292 PUBLIC RI	3,884
4,300	4,300 LICENSE &	40,717
4,310	4,310 DUES & SU	5,378
4,320	4,320 CONTRIBU	(4)
4,350	4,350 PROFESSI(	8,560
4,355	4,355 MEDICAL	18,000
4,362	4,362 MEDICAL	925
4,363	4,363 PHARMAC	1,553
4,364	4,364 SOCIAL SI	4,851
4,370	4,370 TV RENTA	(3,589)
4,383	4,383 BAKCGRO	329
4,390		
4,400	4,400 PAYROLL	101,983
4,401	4,401 PAYROLL	4,977
4,410	4,410 GROUP IN	79,200
4,420	4,420 LIABILITY	57,880
4,430	4,430 WORKMA	18,353
4,435	4,435 W/C-FIRST	2,973
4,436	4,436 DRUG TES	642
4,450	4,450 MANAGEI	205,533
4,460	4,460 BAD DEBT	9,996
4,461	4,461 BAD DEBT	19,503
4,470		
4,475	4,475 UNIFORM	3,913
4,486	4,486 SERVICE (	1,129
4,490	4,490 MISC EXPI	508
4,496	4,496 MISC. M.I.	1,036
4,510	4,510 REAL EST.	17,140
4,600	4,600 LEASED E	9,249
5,110	5,110 MAINTEN.	49,006
5,120	5,120 MAINTEN.	2,799
5,130	5,130 ELECTRIC	38,281
5,131	5,131 NATURAL	6,716
5,133	5,133 WATER &	9,384
5,134	5,134 TRASH CC	6,040
5,140	5,140 PROP/PLA	2,751
5,160	5,160 GENERAL	16,988
5,165	5,165 MAINTEN.	20,318
5,210	5,210 DIETARY	106,086
5,220	5,220 DIETARY I	5,794
5,248	5,248 FOOD PUR	104,727
5,250	5,250 SUPPLIES	2,959
5,260	5,260 REPLACEI	1,955
5,270	5,270 KITCHEN	6,299
5,295	5,295 MEAL INC	(215)
5,310	5,310 LAUNDRY	31,213
5,340	5,340 LAUNDRY	1,608
5,370	5,370 REPLACEI	4,049
5,380	5,380 OUTSIDE I	(5)
5,390	5,390 SUPPLIES	4,686
5,410	5,410 HOUSEKE	48,086
5,440	5,440 HOUSEKE	3,451
5,480	5,480 SUPPLIES-	158
5,490	5,490 SUPPLIES-	14,559
6,020	6,020 RN WAGE	178,118
6,030	6,030 DON WAG	46,621
6,035		
6,040	6,040 RN PTO &	17,933
6,120	6,120 LPN WAGI	76,167
6,140	6,140 LPN PTO &	3,779
6,220	6,220 AIDES WA	356,653
6,240	6,240 AIDES PT(	35,143
6,245		
6,246		
6,247		
6,250		
6,255		
6,260		
6,270	6,270 REHAB W.	72,252
6,275	6,275 REHAB PT	3,990
6,290	6,290 NURSING	49,935
6,295	6,295 NURSING	7,743
6,390	6,390 REPLACEI	3,227
6,490	6,490 OTHER	997
7,280	7,280 DRUG PUI	62,818
7,281	7,281 DRUG PUI	101,079
7,380	7,380 LABORAT	3,578
7,391	7,391 AMBULAI	4,355
7,393	7,393 OTHER A	23
7,510	7,510 ACTIVITII	31,462
7,540	7,540 ACTIVITII	1,860
7,590	7,590 ACTIVITII	1,150
7,620	7,620 PHYSICAL	131,287
7,660	7,660 P.T. SUPPL	939
7,710	7,710 SOCIAL SI	27,174
7,720	7,720 SOCIAL SI	1,361
7,730	7,730 SOCIAL SI	821
7,740	7,740 OCCUPAT	95,337
7,750		
7,770	7,770 SPEECH TI	45,579
7,820	7,820 BEAUTICI	16,930
7,890		
7,960		
8,120	8,120 INTEREST	28,290
8,125		
8,130	8,130 DEPRECIA	96,376
8,150	8,150 LOAN FEE	891
9,510	9,510 INTEREST	(896)
9,520		
9,530	8,100 RENT EXP	274,563
		(344,744)

	G/L	RECAP CENSUS
PP	10,426	10,280
IPA	12,389	12,303
medicare	2,729	2,729
		25,312
IPA BEDHOLDS	86	
PP BEDHOLDS	146	
PP CONVERS	0	